FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022350

Facility Name: WESLEY VILLAGE HEALTH CARE CENTER

Address: 1200 EAST GRANT STREET (Number) MACOMB (City) 61455 (Zip Code)

County: MCDONOUGH

Telephone Number: 309-833-2123 **Fax #** 309-837-7500

IDPA ID Number: 370996594001

Date of Initial License for Current Owners: 4/14/1980

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: SHELLY WARD **Telephone Number:** 309-833-2123

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHELLY WARD

(Title) ADMINISTRATOR/CEO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	9,490	1
2		Skilled Pediatric (SNF/PED)			2
3	47	Intermediate (ICF)	47	17,155	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	73	TOTALS	73	26,645	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,434	4,006		8,440	8
9	SNF/PED					9
10	ICF	9,615	6,943		16,558	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,049	10,949		24,998	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.82%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/14/1980

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 1,048

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: TAX-EXEMPT Fiscal Year: JAN-DEC

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CEN] # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	219,813	15,418	9,132	244,363		244,363		244,363			1
2	Food Purchase		160,865		160,865		160,865	(282)	160,583			2
3	Housekeeping	97,618	9,252	352	107,222	26,911	134,133		134,133			3
4	Laundry	19,306		33,428	52,734		52,734		52,734			4
5	Heat and Other Utilities			88,468	88,468		88,468		88,468			5
6	Maintenance	30,109	13,095	6,871	50,075		50,075		50,075			6
7	Other (specify):*											7
8	**TOTAL General Services**	366,846	198,630	138,251	703,727	26,911	730,638	(282)	730,356			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,246,289	137,821	113,255	1,497,365	(61,976)	1,435,389		1,435,389			10
10a	Therapy											10a
11	Activities	42,005	6,340	6,567	54,912		54,912	(4,242)	50,670			11
12	Social Services					32,961	32,961		32,961			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,288,294	144,161	119,822	1,552,277	(29,015)	1,523,262	(4,242)	1,519,020			16
	C. General Administration											
17	Administrative	143,606			143,606		143,606		143,606			17
18	Directors Fees											18
19	Professional Services			16,685	16,685		16,685		16,685			19
20	Dues, Fees, Subscriptions & Promotions			9,380	9,380	2,104	11,484		11,484			20
21	Clerical & General Office Expenses		21,327		21,327		21,327		21,327			21
22	Employee Benefits & Payroll Taxes			316,044	316,044		316,044		316,044			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,062	10,062		10,062		10,062			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			21,794	21,794		21,794		21,794			26
27	Other (specify):*											27
28	**TOTAL General Administration**	143,606	21,327	373,965	538,898	2,104	541,002		541,002			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,798,746	364,118	632,038	2,794,902		2,794,902	(4,524)	2,790,378			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER #0022350 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			132,617	132,617		132,617		132,617			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			95,797	95,797		95,797		95,797			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			228,414	228,414		228,414		228,414			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,968	39,968		39,968		39,968			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			39,968	39,968		39,968		39,968			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,798,746	364,118	900,420	3,063,284		3,063,284	(4,524)	3,058,760			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	4,242	LN11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	282	LN 2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 4,524		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	7,222	X-F	33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 7,222		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 11,746		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WESLEY VILLAGE HEALTH CARE CENTER

ID# 0022350

Report Period Beginning: 1/1/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER **#** 0022350 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		NOT APPLICABLE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	NOT APPLICABLE		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CEN # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CEN] # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	SUBORDINATED DEBENTURES		X				$ 323,005	$ 246,510	VARIOUS	VARIOUS	$ 9,398	1
2	FIRST FEDERAL BANK		X	ANNUAL PAYMENT 11/05			2,725,000	1,629,002	11/13/2022	4.6500	86,399	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,048,005	$ 1,875,512			$ 95,797	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,048,005	$ 1,875,512			$ 95,797	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER **#** 0022350 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	**8**
	2001	**9**
	2002	**10**
	2003	**11**
	2004	**12**

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESLEY VILLAGE HEALTH CARE CENTER COUNTY MCDONOUGH

FACILITY IDPH LICENSE NUMBER 0022350

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,893 B. General Construction Type: Exterior BRICK Frame PRESTRESSED CON(Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

WESLEY VILLAGE RETIREMENT CENTER 70 UNITS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 144,434
2. Number of Years Over Which it is Being Amortized: 20
3. Current Period Amortization: 7,222
4. Dates Incurred: 2/1/1997-1/31/1998

Nature of Costs: BOND ISSUANCE EXPENSES - 1998 NEW CONSTRUCTION - ALZHEIMER UNIT
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	235,224	1975	$ 48,600	1
2					2
3	TOTALS	235,224		$ 48,600	3

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	47		1980	1980	$ 1,304,649	$ 25,968	50	$ 25,968	$	$ 666,689	4
5	26		1998	1997	1,934,404	50,214	50	50,214		367,134	5
6											6
7											7
8											8
	Improvement Type**										
9	LAND IMPROVEMENTS										9
10	Paved parking lot			1981	28,080		15			28,080	10
11	Landscaping			1981	2,943		10			2,943	11
12	Landscaping			1984	227		10			227	12
13	Blacktop driveway			1985	559		10			559	13
14	Landscaping, Install cement patio			1982	488		20			488	14
15	Landscaping			1983	681		20			681	15
16	Blacktop driveway			1986	2,668		15			2,668	16
17	Blacktop driveway			1987	15,464		15			15,464	17
18	Improve drainage			1987	1,036		15			1,036	18
19	Landscaping costs			1988	599		10			599	19
20	Improve drainage from roof area			1989	946		15			946	20
21	Blacktop sealer			1990	1,396	49	15	49		1,396	21
22	Blacktop sealer			1991	1,054	71	15	71		1,020	22
23	Blacktop sealer			1994	1,307	87	15	87		1,001	23
24	Turf & Garden mix 38%			1997	322	13	10	13		117	24
25	Walking Path 50%			1997	418	10	20	10		90	25
26	Concrete curbing 38%			1997	562	7	20	7		63	26
27	Walking Path 50%			2000	17,911	896	20	896		5,376	27
28	Alzheimer's Garden Enhancement			2000	4,468	223	20	223		1,338	28
29	Walking Path 50%			2001	15,264	890	10	890		4,450	29
30	Glider walking path			2002	1,346	135	10	135		405	30
31	Seal & asphalt drive & parking lot			2003	7,888	367	15	367		1,001	31
32	Landscape gazebo area			2003	1,202	10	10	10		30	32
33	Landscaping around wheelchair swing			2004	856	85	10	85		170	33
34	Landscaping south garden area 50%			2004	5,618	562	10	562		1,124	34
35	Landscape - HC/SCU Signs			2005	519	51	10	51		51	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BUILDING IMPROVMENTS		$	$		$	$	$	37
38	Screens & doors	1981	4,500		10			4,500	38
39	Constructed carports	1981	2,000	40	50	40		960	39
40	Wallpaper	1981	2,264		20			2,264	40
41	Entrance signs	1981	5,920	208	30	208		5,029	41
42	Signs	1981	58		12			58	42
43	Intangibles	1981	5,742		20			5,742	43
44	Overhang roof drain	1982	342		20			342	44
45	Remodel bathroom	1982	371	8	50	8		184	45
46	Exhaust fans & lights	1982	426		20			426	46
47	Carpet	1983	169		5			169	47
48	Install satellite system	1983	4,122		15			4,122	48
49	Remodeling	1983	389	8	50	8		175	49
50	Wheelchair ramp	1984	407		10			407	50
51	Remodel showers	1984	501	17	30	17		341	51
52	Install decoder	1985	450		15			450	52
53	Redecorate resident rooms	1985	10,126		15			10,126	53
54	Install tornado siren	1986	3,056		15			3,056	54
55	Carpet	1987	538		5			538	55
56	Install TV filter	1987	68		15			68	56
57	Redecorate resident rooms	1987	7,274		15			7,274	57
58	Remodeling hallway	1988	68		15			68	58
59	Roof repair	1989	3,704		15			3,704	59
60	Emergency light	1989	35		10			35	60
61	Redecorating	1989	13,802	629	15	629		13,802	61
62	Nurse call system	1990	4,919	315	15	315		4,238	62
63	Elevator jack	1990	3,780	240	15	240		3,600	63
64	Solid core door	1990	735		10			735	64
65	Water system repairs	1991	1,410		10			1,410	65
66	Water heater repairs	1991	1,323		10			1,323	66
67	Replace window panes	1991	9,051	476	20	476		6,889	67
68	Install A/C food service	1992	866	43	20	43		602	68
69	Roof repairs	1992	8,685	579	15	579		8,106	69
70	TOTAL (lines 4 thru 69)		$ 3,449,976	$ 82,201		$ 82,201	$	$ 1,195,889	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,449,976	$ 82,201		$ 82,201	$	$ 1,195,889	1
2	Redesign water system	1992	2,385	95	20	95		1,235	2
3	Remodeling	1992	9,845	656	15	656		8,528	3
4	Carpeting	1993	851	57	15	57		712	4
5	Remodeling	1993	1,540		10			1,540	5
6	New entryway	1994	7,888	484	20	484		5,469	6
7	Remodeling	1994	3,216	322	10	322		3,220	7
8	Painting entryway & carpet	1995	2,456	48	10	48		2,456	8
9	Dining room floor	1996	116	6	20	6		55	9
10	Roof repairs - west end	1996	385	26	15	26		249	10
11	12 Air conditioning units	1996	3,698	247	15	247		2,038	11
12	Shingle east entrance	1997	398	26	15	26		215	12
13	Border resident rooms	1997	484	25	10	25		204	13
14	Carpet installations hallway	1997	265	13	20	13		106	14
15	Vinyl floor covering	1997	1,507	75	20	75		600	15
16	Remote annunicator panel	1997	705	34	20	34		290	16
17	Heating/Air conditioning units	1997	1,602	80	20	80		647	17
18	3 Windows	1997	116	6	20	6		49	18
19	12 Window screens	1997	126	6	20	6		51	19
20	Carpet	1997	432	36	20	36		288	20
21	Drainage from SE corner of building	1997	378	24	15	24		205	21
22	Additional wiring to pass inspection	1998	4,748	237	20	237		1,798	22
23	Window treatments	1998	10,940	547	20	547		4,194	23
24	Mixing valve	1998	2,695	180	15	180		1,290	24
25	Tuckpointing buidling exterior	1998	4,511	180	20	180		1,290	25
26	Flooring	1998	665	44	15	44		349	26
27	New fire alarms in health care	1998	10,468	523	20	523		3,749	27
28	Additional strobes due to inspection	1998	1,381	69	20	69		535	28
29	Roof repairskitchen & SE section	1998	9,060	362	25	362		2,263	29
30	Alzheimer unit lounge flooring	1999	1,074	54	15	54		378	30
31	Health care lighting upgrade	1999	2,019	135	10	135		945	31
32	Fire alarm upgrade	1999	2,814	164	10	164		1,148	32
33	Heating/Cooling laundry room & kitchen corridor	2000	9,000	450	20	450		2,700	33
34	TOTAL (lines 1 thru 33)		$ 3,547,744	$ 87,412		$ 87,412	$	$ 1,244,685	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,547,744	$ 87,412		$ 87,412	$	$ 1,244,685	1
2	Sewer line	2000	8,868	355	25	355		2,130	2
3	Smoking patio	2000	2,590	130	20	130		780	3
4	Decorate Health care dining room	2001	7,887	307	15	307		1,535	4
5	A/C compressor health care core	2001	9,076	202	15	202		1,010	5
6	Wallguards Health Care dining room	2001	970	32	15	32		160	6
7	Kitchen walk-in cooler compressor	2001	1,769	253	7	253		1,265	7
8	Generator health care	2001	989	24	7	24		120	8
9	Alzheimer water system	2001	14,079	469	20	469		2,345	9
10	Glider walking path	2002	1,346	135	10	135		540	10
11	Storage shed - cement work	2002	9,357	468	20	468		1,872	11
12	Health care core area roof	2002	8,800	440	20	440		1,760	12
13	Outside doors - HC center hall	2003	5,600	560	10	560		1,680	13
14	Health Care center shower room tile	2003	1,475	147	10	147		441	14
15	Health care center core area remodeling	2003	1,000	100	10	100		200	15
16	Water softening system	2003	12,470	1,247	10	1,247		3,741	16
17	Garage/Storage	2003	17,861	893	20	893		2,679	17
18	Health Care center dining room remodeling	2004	27,065	1,804	15	1,804		3,608	18
19	Health care center core area floor plans-architect	2004	7,414	494	15	494		988	19
20	Garage/Storage 50%	2004	1,737	87	20	87		174	20
21	Carpet - 7 rooms Health care	2004	3,910	260	15	260		520	21
22	Health Care Center activity room remodeling	2005	2,606	261	10	261		261	22
23	Food service department drain	2005	2,655	265	10	265		265	23
24	Heatlh Care Center door locks	2005	529	53	10	53		53	24
25	Health Care Center Doors	2005	4,395	440	10	440		440	25
26	A/C units	2005	5,291	529	10	529		529	26
27	Garage/Workshop 50%	2005	927	46	20	46		46	27
28	Outdoor electrical	2005	1,464	98	15	98		98	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,709,874	$ 97,511		$ 97,511	$	$ 1,273,925	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 666,234	$ 31,057	$ 31,057	$		$ 175,033	71
72	Current Year Purchases	40,485	4,049	4,049			4,049	72
73	Fully Depreciated Assets	27,509					27,509	73
74								74
75	TOTALS	$ 734,228	$ 35,106	$ 35,106	$		$ 206,591	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,492,702	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 132,617	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 132,617	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,480,516	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER **#** 0022350 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 213,056	$ 355,094	1
2	Cash-Patient Deposits	197,775	305,089	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)	27,724	45,854	4
5	Short-Term Investments		1,005,234	5
6	Prepaid Insurance	6,352	12,459	6
7	Other Prepaid Expenses		26,299	7
8	Accounts Receivable (owners or related parties)		107,650	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 444,907	$ 1,857,679	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	195,685	287,772	12
13	Land	48,600	180,000	13
14	Buildings, at Historical Cost	3,758,474	7,983,894	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	734,228	1,314,968	16
17	Accumulated Depreciation (book methods)	(1,480,516)	(4,438,990)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	144,404		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(57,776)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		1,121,088	22
23	Other(specify):		8,465	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,343,099	$ 6,457,197	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,788,006	$ 8,314,876	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 21,139	$ 35,231	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	34,689	143,342	29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED EXPENSES	169,260	236,890	36
37	MEMBER FEE, APT DEP,ANNUITY	245,000	672,151	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 470,088	$ 1,087,614	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	246,510	913,000	39
40	Mortgage Payable	1,629,002	2,291,908	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		204,609		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,080,121	$ 3,204,908	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,550,209	$ 4,292,522	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,237,797	$ 4,022,354	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,788,006	$ 8,314,876	48

***(See instructions.)**

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,459,353	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,459,353	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(221,556)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (221,556)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,237,797	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,724,214	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,724,214	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	112,990	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 112,990	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,837,204	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	730,356	31
32	Health Care	1,519,020	32
33	General Administration	541,002	33
	B. Capital Expense		
34	Ownership	228,414	34
	C. Ancillary Expense		
35	Special Cost Centers	39,968	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,058,760	40
41	**Income before Income Taxes (line 30 minus line 40)****	(221,556)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (221,556)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,950	2,080	$ 47,000	$ 22.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,802	7,150	152,300	21.30	3
4	Licensed Practical Nurses	16,721	18,090	342,090	18.91	4
5	CNAs & Orderlies	56,648	59,879	591,000	9.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,960	2,080	22,000	10.58	9
10	Activity Assistants	2,000	2,450	21,500	8.78	10
11	Social Service Workers	1,964	2,082	32,961	15.83	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	26,000	12.50	13
14	Head Cook	2,008	2,245	22,000	9.80	14
15	Cook Helpers/Assistants	14,680	15,520	120,670	7.78	15
16	Dishwashers	7,200	7,540	53,211	7.06	16
17	Maintenance Workers	2,050	2,175	31,090	14.29	17
18	Housekeepers	11,205	11,699	89,500	7.65	18
19	Laundry	2,395	2,510	18,005	7.17	19
20	Administrator	1,960	2,080	62,400	30.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,014	5,467	70,321	12.86	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,424	3,675	45,345	12.34	31
32	Other Health Care(specify)					32
33	Other(specify)	2,507	2,745	51,353	18.71	33
34	TOTAL (lines 1 - 33)	142,448	151,547	$ 1,798,746 *	$ 11.87	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	146	$ 3,889	LN1 COL3	35
36	Medical Director				36
37	Medical Records Consultant	3	100	LN10 COL3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	10	3,000	LN10 COL3	39
40	Physical Therapy Consultant	15	870	LN10A COL3	40
41	Occupational Therapy Consultant	1	60	LN10A COL3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	1,334	LN11 COL3	44
45	Social Service Consultant	19	1,334	LN10A COL3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	213	$ 10,587		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SHELLY WARD		0	$ 62,400
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 62,400

B. Administrative - Other

Description	Amount
NOT APPLICABLE	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
CLIFTON-GUNDERSON	AUDIT/ACCOUNTING	$ 14,185
MARCH & MCMILLAN	LEGAL	2,500
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 16,685

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,019
Unemployment Compensation Insurance	
FICA Taxes	130,260
Employee Health Insurance	129,765
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 316,044

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	480
Health Care Worker Background Check	1,624
(Indicate # of checks performed 135)	
DUES-SEE ATTACHED SCHEDULE	7,390
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,484

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	10,062
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,062

**See instructions.

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LIFE SERVICES NETWORK**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,634** Line **10 COL3**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **39,968**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **CLIFTON GUNDERSON & CO** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **FINAL COPY NOT RECEIVED**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.